Complete Summary

GUIDELINE TITLE

Pediatric care recommendations for freestanding urgent care facilities.

BIBLIOGRAPHIC SOURCE(S)

Committee on Pediatric Emergency Medicine. Pediatric care recommendations for freestanding urgent care facilities. Pediatrics 2005 Jul;116(1):258-60. [6 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

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COMPLETE SUMMARY CONTENT

SCOPE
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SCOPE

DISEASE/CONDITION(S)

Injuries or illness requiring urgent care

GUIDELINE CATEGORY

Evaluation
Management

CLINICAL SPECIALTY

Critical Care
Emergency Medicine
Family Practice
Pediatrics

INTENDED USERS

Allied Health Personnel
Nurses
Physicians

GUIDELINE OBJECTIVE(S)

To provide updated and expanded recommendations for ensuring appropriate stabilization in pediatric emergency situations and timely and appropriate transfer to a hospital for definitive care when necessary

TARGET POPULATION

Critically ill and injured children

INTERVENTIONS AND PRACTICES CONSIDERED

1. Ensuring freestanding urgent care facility emergency preparedness
2. Understanding pediatrician's role in freestanding urgent care facilities (referrals and providing consultation)

MAJOR OUTCOMES CONSIDERED

Not stated

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Medline and PubMed were searched using keywords "urgent care centers" and "urgent care facilities;" articles or books identified by committee members.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Subjective Review

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Freestanding Urgent Care Facility Emergency Preparedness

1. Administrators at freestanding urgent care facilities should ensure that their staff is capable of providing resuscitation, stabilization, timely triage, and appropriate transfer of all pediatric patients.
2. Although the minimum standards for drugs, equipment, and supplies are listed in Tables 1 and 2 below, freestanding urgent care facilities with emergency medical systems response times of >10 minutes and transport times of >20 minutes to an emergency department need to have all suggested equipment, resuscitation drugs, and supplies as detailed in "Care of Children in the Emergency Department: Guidelines for Preparedness," issued jointly by the American Academy of Pediatrics (AAP) and American College of Emergency Physicians (AAP, 2001).
3. Freestanding urgent care facilities that provide care for children must be staffed by physicians, nurses, and ancillary health care professionals with the certification, experience, and skills necessary for pediatric basic and advanced life support during all hours of operation.
4. Triage, transfer, and transport agreements should be prearranged with definitive care facilities that are capable of providing the appropriate level of care based on the acuity of illness or injury of the child (AAP, 2000).
5. Mechanisms for notifying the primary care physician or another on-call health care professional about the treatment given to ensure appropriate follow-up with the child's medical home should be in place and should be compliant with the regulations of the Health Insurance Portability and Accountability Act (HIPAA) (Pub L No. 101-191 [1996]). If a primary care physician is not identified, efforts should be made to refer the patient to a pediatrician able to promote a medical home environment.
6. Administrators at freestanding urgent care facilities must ensure that there is an organized and structured quality-improvement program to monitor and improve care for ill or injured children.
7. Freestanding urgent care facilities should have in place and should monitor compliance with policies, procedures, and protocols for emergency care of children consistent with those listed in "Care of Children in the Emergency Department: Guidelines for Preparedness" (AAP, 2001).
8. Freestanding urgent care facilities should have a policy for disaster preparedness and participate in their community disaster plan ("The pediatrician's role," 1997).

Table 1: Office Emergency Equipment and Supplies

	Priority*
Airway Management	
Oxygen-delivery system	E
Bag-valve-mask (450 and 1000 mL)	E
Clear oxygen masks, breather and nonrebreather, with reservoirs (infant, child, adult)	E
Suction device, tonsil tip, bulb syringe	E
Nebulizer (or metered-dose inhaler with spacer/mask)	E
Oropharyngeal airways (sizes 00-5)	E
Pulse oximeter	E
Nasopharyngeal airways (sizes 12-30F)	S
Magill forceps (pediatric, adult)	S
Suction catheters (sizes 5-16F) and Yankauer suction tip	S

	Priority*
Nasogastric tubes (sizes 6-14F)	S
Laryngoscope handle (pediatric, adult) with extra batteries, bulbs	S
Laryngoscope blades (straight 0-4; curved 2-3)	S
Endotracheal tubes (uncuffed 2.5-5.5; cuffed 6.0-8.0)	S
Stylets (pediatric, adult)	S
Esophageal intubation detector or end-tidal carbon dioxide detector	S
Vascular Access and Fluid Management	
Butterfly needles (19-25 gauge)	S
Catheter-over-needle device (14-24 gauge)	S
Arm boards, tape, tourniquet	S
Intraosseous needles (16, 18 gauge)	S
Intravenous tubing, microdrip	S
Miscellaneous Equipment and Supplies	
Color-coded tape or preprinted drug doses	E
Cardiac arrest board/backboard	E
Sphygmomanometer (infant, child, adult, thigh cuffs)	E
Splints, sterile dressings	E
Automated external defibrillator with pediatric capabilities	E
Spot glucose test	S
Stiff neck collars (small/large)	S
Heating source (overhead warmer/infrared lamp)	S

* E indicates essential; S, strongly suggested (essential if emergency medical services response time is >10 minutes).

Table 2: Office Emergency Drugs

	Priority*
Drugs	
Oxygen	E
Albuterol for inhalation**	E
Epinephrine (1:1000)	E
Activated charcoal	S
Antibiotics	S
Anticonvulsants (diazepam, lorazepam)	S
Corticosteroids (parenteral/oral)	S
Dextrose (25%)	S
Diphenhydramine (parenteral, 50 mg/mL)	S
Atropine sulfate (0.1 mg/mL)	S
Naloxone (0.4 mg/mL)	S
Sodium bicarbonate (4.2%)	S
Fluids	
Normal saline solution or lactated Ringer's solution (500-mL bag)	S
5% Dextrose, 0.45 normal saline (500-mL bags)	S

*E indicates essential; S, strongly suggested (essential if emergency medical services response time is >10 minutes).
**Metered-dose inhaler with spacer or mask may be substituted.

Pediatrician's Role in Freestanding Urgent Care Facilities

1. Pediatricians should refer patients for after-hours care only to freestanding urgent care facilities that have the capability to identify patients with emergency conditions, stabilize them, and arrange transfer for definitive care.
2. When referring a patient, the pediatrician should provide to the freestanding urgent care facility necessary clinical information and be available to provide consultation.

If freestanding urgent care centers are staffed and equipped properly and have appropriate triage, transfer, and transport guidelines, the safety of children using these services for emergencies can be protected.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Appropriate stabilization of pediatric emergency patient in freestanding urgent care facilities and timely and appropriate transfer to a hospital for definitive care when necessary
- If freestanding urgent care centers are staffed and equipped properly and have appropriate triage, transfer, and transport guidelines, the safety of children using these services for emergencies can be protected.

POTENTIAL HARMS

Not stated

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness
Timeliness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2005 Jul

GUIDELINE DEVELOPER(S)

American Academy of Pediatrics - Medical Specialty Society

SOURCE(S) OF FUNDING

American Academy of Pediatrics

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Committee on Pediatric Emergency Medicine

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

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GUIDELINE AVAILABILITY

Electronic copies: Available from the American Academy of Pediatrics (AAP) Policy Web site.

Print copies: Available from American Academy of Pediatrics, 141 Northwest Point Blvd., P.O. Box 927, Elk Grove Village, IL 60009-0927.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

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